

**Health Care and Dependent Care
Flexible Spending Account Enrollment Form**

(Please Print)

Employee Name: _____ Social Security No. _____
Address: _____ Employee ID No. _____
City _____ Pay Frequency: Wkly. _____ Mthly. _____
State, Zip _____ Effective Date: _____

Health Care Reimbursement Account

I hereby authorize Fermilab to reduce my earnings for the current plan year for deposit into my Health Care Reimbursement Account and to make this money available to me for the reimbursement of eligible out-of-pocket health expenses. ***I UNDERSTAND THAT I WILL FORFEIT ANY UNUSED BALANCE IN MY ACCOUNT AT THE END OF THE PLAN YEAR FILING PERIOD. I ALSO UNDERSTAND THAT I CANNOT CHANGE MY PLAN PARTICIPATION UNLESS I HAVE A CHANGE IN FAMILY STATUS, AS DEFINED BY INTERNAL REVENUE CODE SECTION 125.***

Annual Contribution Amount \$ _____ (Maximum Contribution is \$4000)

Signature _____ Date _____

Dependent Care Reimbursement Account

I hereby authorize Fermilab to reduce my earnings for the current plan year for deposit into my Dependent Care Reimbursement Account and to make this money available to me for the reimbursement of eligible out-of-pocket dependent care expenses. ***I UNDERSTAND THAT I WILL FORFEIT ANY UNUSED BALANCE IN MY ACCOUNT AT THE END OF THE PLAN YEAR FILING PERIOD. I ALSO UNDERSTAND THAT I CANNOT CHANGE MY PLAN PARTICIPATION UNLESS I HAVE A CHANGE IN FAMILY STATUS, AS DEFINED BY INTERNAL REVENUE CODE SECTION 125.***

Annual Contribution Amount \$ _____ (Maximum contribution is \$5000)

Signature _____ Date _____

NOTE: Salary reduction elections must be made in whole dollar amounts. These elections will be divided by the number of pay periods in the current plan year and be credited to your Account or Accounts on a monthly basis. Your salary reduction is made on a pre-tax basis in accordance with the IRS Section 125 guidelines.

For Departmental Use Only

Health Care: Goal Amount \$ _____ Effective _____
Dependent Care: Goal Amount \$ _____ Effective _____